AUTHORIZATON FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. **Failure to provide *all* information requested may invalidate this Authorization.**

I hereby authorize the use and/or disclosure of my health information as described in 6 and/or 6a below.

1. Patient Name: _____ DOB: _____ SSN: _____
2. **Authorize:**

   ANN L. MAI, M.D.
   4950 Barranca Parkway, Suite 207
   Irvine, California 92604 USA
   Phone (949) 262-9700 / (949) 262-0700 Fax

3. **To release protected health information to:**
   Physician / Facility _____
   Address _____
   City / Zip _____
   Phone / Fax _____

4. **Authorize:**
   Physician / Facility _____
   Address _____
   City / Zip _____
   Phone / Fax _____

5. **To release protected health information to:**
   Ann L. Mai, M.D.
   4950 Barranca Parkway, Suite 207
   Irvine, California 92604 USA
   Phone (949) 262-9700 / (949) 262-0700 Fax

6. **HEALTH INFORMATION TO BE RELEASED FOR THE FOLLOWING DATES: (Invalid if dates/period not filled in)**
   From _____ to _____.
   ___ OB/Gyn Records ___ Lab Reports ___ Billing Records – Specify
   ___ Specific Visits ___ X-Ray Reports ___ Other (please specify) _____

6a. In compliance with California Statutes which require special permission to release otherwise privileged information, please release records pertaining to: (separate specific authorization required)
___ Mental Health ___ Drug Abuse ___ Alcohol Abuse ___ HIV Tests

7. **PURPOSE OR NEED FOR DISCLOSURE: (Check all that apply – you must choose at least ONE)**
___ Further Medical Care ___ Disability Determination ___ Workers' Compensation
___ At the Request of the Patient ___ Life Insurance Determination ___ Research Drug Study
___ Employment Determination ___ Legal Investigation ___ Other

8. **EXPIRATION DATE:**
This Authorization will expire on ___/___/____. If I do not indicate a date, this authorization will expire one (1) year from the date of my signature on this document.

9. SIGNATURE: _____ Date: _____
If signed by someone other than the patient, state your legal relationship to the patient: _____
Witness: _____
If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be disclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.

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ADDITIONAL INFORMATION REGARDING RELEASE OF HEALTH INFORMATION

This office recognizes the patient's right of confidentiality of their health information under federal privacy regulations and California law. The patient should be aware of the following information when requesting or releasing health information:
Right to Refuse to Sign this Authorization: This authorization is voluntary. Refusal to sign **will not** affect the patient's ability to receive treatment or payment of claims.
Right to Inspect or Receive a Copy of Health Information to Be Used or Disclosed: A patient has a right to inspect or obtain a copy of the health information they have authorized to be used or disclosed by signing this Authorization form.
Right to Receive a Copy of this Authorization: A patient has the right to receive a copy of the signed Authorization form.
Right to Revoke this Authorization: A patient has the right to revoke this Authorization at any time by giving written notice of revocation to the Privacy Officer. Revocation of this Authorization will not affect any action taken in reliance of this Authorization before receipt of the written notice of revocation.
Multiple Releases of Information: A patient may request multiple releases of the information stated on the Authorization form.